



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR ORTHOPEDIC AND SPINE HOSPITAL
707 HIGHLANDER BLVD
ARLINGTON TX 76015-4319

Respondent Name

LM INSURANCE CORP

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-11-3004-01

MFDR Date Received

May 4, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Requested 200% of Medicare APC; appealed and carrier upheld original payment decision in error."

Amount in Dispute: \$6,687.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider requested reimbursement at 200% of the APC rate indicating implants should be reimbursed as inclusive; however, implants were billed by and paid to another provider (Access Mediquip). Therefore, the provider was correctly reimbursed for the services performed."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2011	Outpatient Hospital Services	\$6,687.88	\$6,687.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)

- U401 – THIS MULTIPLE PROCEDURE WAS REDUCED 50 PERCENT ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES. (U401)
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- Z346 – RIGHT SIDE. (Z346)
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED. (B291)

Issues

1. Did the respondent support the insurance carrier's reasons for reducing reimbursement for the disputed services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The respondent's position statement asserts that "implants were billed by and paid to another provider." In support of this statement, the respondent has provided a copy of an explanation of benefits and a bill from a surgical implant provider supporting that the insurance carrier made payment on a bill for 2 units of HCPCS code L8699 provided to the injured worker on service date January 25, 2011. HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified." Review of the submitted information finds no documentation that describes the alleged implantable items or how they were applied to the injured worker. The respondent did not provide documentation of the manufacturer's invoice amount or net amount for the alleged implantables. Nor was documentation found to support that the bill for the implantable items included the certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable, as required by 28 Texas Administrative Code §134.403(g)(1). Review of the records submitted for the services in dispute finds no documentation that prosthetic implants, or implants of any kind, were implanted or otherwise applied to the injured worker during the surgery or encounter during which the services in dispute were rendered. The Division concludes that the respondent has provided insufficient evidence to establish that a surgical implant provider requested separate reimbursement in accordance with the requirements of subsection 134.403(g) for implantable items that were related to the services in dispute. The insurance carrier's reason for reducing or denying payment is therefore not supported. Moreover, per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR [medical dispute resolution] was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was submitted to support that this denial reason or defense was ever presented to the requestor prior to the date the request for MDR was filed. Therefore, this newly raised defense shall not be considered in this review.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. As discussed above, review of the submitted documentation finds that separate reimbursement for implantables was not requested with regards to the services in dispute.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,336.55. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,001.93. This amount multiplied by the annual wage index for this facility of 0.956 yields an adjusted labor-related amount of \$1,913.85. The non-labor related portion is 40% of the APC rate or \$1,334.62. The sum of the labor and non-labor related amounts is \$3,248.47. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2011 Default CCR as 0.2157. This ratio multiplied by the billed charge of \$8,477.00 yields a cost of \$1,828.49. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$3,248.47 divided by the sum of all APC payments is 41.19%. The sum of all packaged costs is \$987.37. The allocated portion of packaged costs is \$406.67. This amount added to the service cost yields a total cost of \$2,235.16. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total APC payment for this service is \$3,248.47. This amount multiplied by 200% yields a MAR of \$6,496.94.
- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,336.55. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,001.93. This amount multiplied by the annual wage index for this facility of 0.956 yields an adjusted labor-related amount of \$1,913.85. The non-labor related portion is 40% of the APC rate or \$1,334.62. The sum of the labor and non-labor related amounts is \$3,248.47. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple procedure discount, is \$1,624.24. This amount multiplied by 200% yields a MAR of \$3,248.48.
- Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,064.02. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,238.41. This amount multiplied by the annual wage index for this facility of 0.956 yields an adjusted labor-related amount of \$1,183.92. The non-labor related portion is 40% of the APC rate or \$825.61. The sum of the labor and non-labor related amounts is \$2,009.53. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple procedure discount, is \$1,004.77. This amount multiplied by 200% yields a MAR of \$2,009.54.
- Procedure code 29822 is a component service of procedure code 29827 performed on the same date. Per Medicare policy, these two codes may not be reported on the same date of service unless a modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Review of the submitted medical documentation finds that modifier 59 is supported; therefore separate payment is allowed. Procedure code 29822 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,064.02. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,238.41. This amount multiplied by the annual wage index for this facility of 0.956 yields an adjusted labor-related amount of \$1,183.92. The non-labor related portion is 40% of the APC rate or \$825.61. The sum of the labor and non-labor related amounts is \$2,009.53. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple procedure discount, is \$1,004.77. This amount multiplied by 200% yields a MAR of \$2,009.54.
- Procedure code 29999 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,064.02. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,238.41. This amount multiplied by the annual wage index for this facility of 0.956 yields an adjusted labor-related amount of \$1,183.92. The non-labor related portion is 40% of the APC rate or \$825.61. The sum of the labor and non-labor related amounts is \$2,009.53. The cost of this service does not exceed the

annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including multiple procedure discount, is \$1,004.77. This amount multiplied by 200% yields a MAR of \$2,009.54.

- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.68. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of \$10.00. The recommended payment is \$10.00.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 80051 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.87. 125% of this amount is \$12.34. The recommended payment is \$12.34.
 - Procedure code 93005 is unbundled from other services billed. Per Medicare policy, payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
5. The total allowable reimbursement for the services in dispute is \$15,800.13. The amount previously paid by the insurance carrier is \$8,944.45. The requestor is seeking additional reimbursement in the amount of \$6,687.88. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$6,687.88.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$6,687.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

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Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	October 3, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.